MEDPAC Medicare Payment Advisory Commission

MEETNG BRIEF

April 25, 2002

Beneficiaries' access to Medicare hospice care

ISSUE: Do terminally ill Medicare beneficiaries have difficulty accessing hospice care? Do rural beneficiaries have poorer access to hospice care than their urban counterparts? To address these questions, the Congress required MedPAC to study beneficiaries' access to and use of hospice care and to report in June 2002.

KEY POINTS: Beneficiaries had greater access to hospice care in 2000 than in the early 1990s, as evidenced by two indicators: beneficiaries' use of care and supply of providers. The number of beneficiaries and percentage of decedents using hospice tripled from 1992 to 2000—23 percent of Medicare decedents and 60 percent of those beneficiaries who died of cancer used hospice in 2000. Hospice users of every type increased during this period with the greatest growth among beneficiaries with non-cancer diagnoses, and those living in nursing homes or rural areas. The number of Medicare hospices almost doubled from 1992 to 2002. Fewer than 1 percent of decedents lived in areas with no hospice available in 2000.

Some individuals express concern that short hospice stays indicate access problems. From 1992 to 2000, the fraction of hospice patients dying within one week of admission increased from 21 percent to 30 percent. We conclude that Medicare policies are not a major contributor to shorter hospice stays. Instead, the main causes of these late referrals appear to be 1) the difficulty of making prognoses of death within six months, 2) beneficiaries' unwillingness to give up curative care, and 3) greater availability of non-debilitating therapies. We also conclude that Medicare policies are not a barrier to beneficiaries accessing hospice care.

To ensure beneficiaries' continued access to hospice care, Medicare payment rates must be adequate. Currently, rates are based on old information from a Medicare demonstration project in the early 1980s. Although the initial rates have been updated for inflation over time, they probably are not consistent with the costs that efficient hospices incur in furnishing appropriate care. Rapid growth in providers can mean that rates are too generous, although others maintain that rates are too low. An evaluation of rates that is more than estimating the relationship of payments to costs is needed. Hospice rates are not case-mix adjusted. Research to determine whether such a system is feasible is necessary before such a system can be established. Research to study ways to establish a high-cost outlier policy also is needed. The research on outlier policies should include both methods that can be implemented with existing payment policy and methods that might be used with a case-mix adjusted system.

Draft recommendations are to: 1) reevaluate payment rates and 2) research whether a case-mix adjusted payment system is feasible and study ways to establish a high-cost outlier policy.

ACTION: Commissioners will discuss the draft report and vote on draft recommendations. The results will be incorporated in the report to the Congress. This will be Commissioners' final review of the report.

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